PATIENT UPDATE

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

E-mail address for appointment reminders _____

Purpose of this appointment today _____

_____

_____

Specific reason for break in care (No pain, just had a baby, illness, travelling, etc.):

_____

_____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any new symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

Current Height _____ Weight _____ Shoe size _____

Current Insurance Information:

Insurance Company _____

Phone number _____

ID number _____

Subscriber Name (self/spouse/parent) _____

****** PLEASE COMPLETE OTHER SIDE ******

PATIENT UPDATE

1. What is your major symptom? _____
2. On a scale of 1-10 (10 being the worst) please rate your pain:
   Currently _____ At its best _____ At its worst _____
3. When was the first time you noticed this problem? _____
   How did it originally occur? _____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____ If yes, describe _____
   Are there other unrelated health problems? Yes _____ No _____ If yes, describe _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___ If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. Have you had any broken bones? Yes ____ No ____ If yes, please list and give dates _____
   _____
10. List any major accidents you have had other than those that might be mentioned above: _____
    _____
11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____ If yes, please explain _____
    _____
12. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____ Expected Due Date _____
13. Remarks: _____
    _____
    _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____